

STATE OF WASHINGTON
DEPARTMENT OF LABOR AND INDUSTRIES
PO Box 44261 Olympia, Washington 98504-4261

BILLING INSTRUCTIONS – STATE FUND CLAIMS
HCFA – 1500 BILL FORM
F245-127-000

*Anesthesiologist, Chiropractor, CRNA, Hospital ER/Professional Services,
Laboratories, Naturopath, Osteopathic Physician, Outpatient Pain Management
Program, Panel Examiner, Pathologist, Physical Therapist, Physician,
Physician Assistant, Physician Clinic, Podiatric Physician, Psychologist, Radiologist*

Table of Contents

BILLING INSTRUCTIONS	3
L&I Provider Account Number Required:.....	3
Billing on Paper Forms:	3
Bill Forms – Where and How to get them:	3
Billing Electronically:	3
When to Submit Bills:.....	3
When payments are made:	3
Limits on Bill Processing:.....	4
For Help:.....	4
REPORTING REQUIREMENTS	5
PROVIDER SPECIFIC INSTRUCTIONS.....	6
Anesthesiologist.....	6
Chiropractor	6
CRNA	7
Hospital ER/Professional Services.....	7
Laboratories	8
Naturopath.....	8
Osteopathic Physician.....	8
Outpatient Pain Management.....	8
Panel Examiner	9
Pathologist.....	9
Physical Therapist.....	9
Physician and Physician Clinics	9
Physician Assistants	9
Podiatric Physician.....	10
Psychologist	10
Radiologist.....	10
COMPLETING THE “HCFA-1500” FORM	12
SAMPLE BILL FORMS	16
REBILLS	32
ADJUSTMENTS	32
TYPE OF SERVICE CODES:.....	37
PLACE OF SERVICE CODES:	37
FIELD SERVICE OFFICES	38

BILLING INSTRUCTIONS

Labor and Industries (L&I) processes all provider bills using an automated system called the Medical Information Payment System (MIPS). In order to process your bills promptly and accurately, they must be completed as described in these instructions. Improperly submitted bills will be denied or returned for completion or correction.

For billing requirements for Self-Insurers and their service companies contact the Self-Insurance section at 360-902-6901.

L&I Provider Account Number Required:

If you do not have an L&I provider account number, please call Provider Accounts at (360)902-5140 to request a provider application form. This form and several other of the most frequently requested forms can be downloaded from our website at www.wa.gov/lni/forms. You may also request additional forms from your local field service location; a list of these locations is contained on the last page of this billing instruction booklet. Submit your bill after you receive your L&I provider account number or for your first submission only, attach it to your completed application.

Billing on Paper Forms:

Submit charges on the "HCFA-1500" bill form (F245-127-000).

Mail HCFA-1500 bill forms to:

Department of Labor and Industries
PO Box 44269
Olympia, Washington 98504-4269

Bill Forms – Where and How to get them:

Bills must be submitted on ORIGINAL (not photocopied) HCFA-1500 bill forms. Bill forms are furnished free of charge to providers. To order forms, contact the Labor and Industries Field Service Location office nearest you; a listing of these locations is contained on the last page of this billing instruction booklet. Providers outside Washington State may contact Provider Accounts at (360) 902-5140 or the Provider Hotline at 1-800-848-0811. When ordering, give your full name, address, L&I provider account number, quantity needed for six months, and the L&I form number (FXXX-XXX-000) for single sheet, or FXXX-XXX-111 for continuous pinfeed).

Billing Electronically:

Please contact the Electronic Billing Unit at (360) 902-6511 or (360) 902-6512 if you are able to and are interested in submitting bills electronically.

When to Submit Bills:

You should submit bills at the time the first required report is written. Billings should then be sent every 30 days thereafter until the conclusion of services. A separate bill form must be completed for each claim number but each bill form may contain more than one date of service. All dates of service must be billed separately.

When payments are made:

The department issues warrants to providers every two-weeks for bills that have processed to final status. An L&I Remittance Advice is also provided to you at two-week intervals. Remittance Advices provide a report of the status of your bill(s) that have been processed, or are in process. When contacting the department with a billing problem, please have the appropriate copy of the Remittance Advice in hand before calling. Many billing questions can be answered by reading the Remittance Advice.

Credit Balance Bills (CRE) – The bills will be held in abeyance until the credit balance is satisfied. These bills should be treated as “Bills in Process”. Do not post or rebill these bills as long as they appear in this section.

This is money owed to the department. Payment(s) to clear your credit balance should be mailed to:

Department of Labor and Industries

Cashier's Office

PO Box 44835

Olympia WA 98504-4835

Limits on Bill Processing:

Bills must be received within one year of the date of service to be considered for payment. Rebills must be submitted for services denied if a claim was closed and subsequently reopened or if a claim or diagnosis was rejected and subsequently allowed. In these instances, the rebill must be received within one year of the date the final order is issued, which subsequently reopens or allows the claim or diagnosis.

For Help:

If you have questions about “PAID BILLS”, “DENIED BILLS” or “ADJUSTMENT BILLS”, please call the Provider Hotline at 1-800-848-0811. **Please have a copy of the appropriate Remittance Advice in hand before calling.**

If you have questions about “BILLS IN PROCESS”, please call the automated Claim Information line at 1-800-831-5227, for up to the minute bill status. From that line, you may choose the “zero” option to be connected to the Bill Payment Unit.

If you have general questions about an injured workers claim or time-loss payment, please call the automated Claims Information line at 1-800-831-5227. More than one claim number can be accessed per phone call and any ‘wait time’ is minimal.

If an injured worker has general questions about their claim, please give them the 1-800-831-5227 number or the 1-800-LISTENS (547-8367) number for assistance with claim problems including time-loss. If they have bill questions, you may give them the Provider Hotline number 1-800-848-0811.

Note: A completed Report of Accident does not constitute a bill. Bills must be submitted separately to be considered for payment.

REPORTING REQUIREMENTS

DO NOT ATTACH REPORTS TO THE BILLS

The following required **reports** and **documentation** must be sent separately from your bills in order for them to be routed to the proper department and placed in the proper file:

- a. Consultation reports
- b. Laboratory and X-ray reports
- c. Special reports and/or narratives to support level of office visit or procedure
- d. Operative reports/anesthesia records
- e. Periodic office notes
- f. Periodic chart notes

The injured workers' name and claim number must be placed in the upper right corner of each page on any correspondence or report.

The cost invoices for supplies furnished are not routinely required to be mailed to the department, but may be requested in specific cases.

See WAC 296-20 for additional requirements and report definitions.

Send all reports and documentation for State Fund claims to:

Department of Labor and Industries
PO Box 44291
Olympia WA 98504-4291

PROVIDER SPECIFIC INSTRUCTIONS

Anesthesiologist

Type of Service:

Use Type of Service code “3” with CPT, HCPCS and Local Codes

Modifiers

CPT Modifiers: -23 & -99

HCPCS Modifier: -AA, -QK and -QY

Anesthesiologists must have valid individual L&I provider account numbers to be paid for services. The department does not cover anesthesia assistant services.

Anesthesia is not payable for procedures that are not covered by the department. Non-covered codes are listed in Appendix E of the “Washington RBRVS Payment Policies” section in the current Medical Aid Rules and Fee Schedules.

Anesthesia services paid with base and time units must be billed using CPT anesthesia codes 00100 through 01999 or ASA codes 01951 and 01952. Refer to “Anesthesia Services Paid with Base and Time Units” in the Anesthesia Payment Policies section in the current Medical Aid Rules and Fee Schedules.

Effective for dates of service on or after July 1, 2000, anesthesia reimbursement will be calculated using 15-minute time units. This change does not affect how providers bill for services, or how the department calculates payments. Providers should continue to bill for services in one-minute time units.

For more information, please refer to the “Anesthesia Payment Calculation” section of the current Medical Aid Rules and Fee Schedules, and to the current PB 00-05. Provider Bulletins can be viewed/downloaded from www.wa.gov/lni/hsa/hsa_pbs.htm.

Chiropractor

Type of Service:

Use Type of Service code “C” with CPT, HCPCS and Local Codes

The department will not pay chiropractic physicians for additional codes that are not specifically allowed. Refer to the appendices in the “Washington RBRVS Payment Policies” section in the current Medical Aid Rules and Fee Schedules.

Chiropractic Care Visit Payment Policies

- Only **one** chiropractic care visit code is payable per day.
- Chiropractic care visit codes are payable in addition to E/M office visit codes **only when all of the following conditions are met:**
 - The E/M service is for the **initial visit** for a **new claim**, and
 - The E/M service constitutes a significant separately identifiable service that exceeds the usual pre and post service work included in the chiropractic care visits, and
 - Modifier -25 is added to the new patient E/M code, and
 - Supporting documentation describing the service(s) provided is included in the patient’s record.

- Office visits in excess of 20 visits or 60 days require prior authorization.
- Modifier -22 will be individually reviewed when billed with chiropractic care visit local codes (2050A to 2052A). A report is required detailing the nature of the unusual service and the reason it was required. Payment will vary based on findings of the review. No payment will be made when this modifier is used for non-covered or bundled services (for example: application of hot or cold packs).
- When a reopening application is filed, the services required to complete the application will be paid regardless of the insurer's action on the application:
 - When performed on the same day as completion of the reopening application (local code 1041M), an E/M visit (with -25 modifier when a chiropractic treatment code is also billed) and covered diagnostic studies (including x-rays) will be paid.
 - Treatment procedures on the same date and subsequent to the application date will only be paid if the claim is reopened, as no treatment is payable on denied reopenings (closed claims).

For more information, please refer to WAC 296-23-195 and the “Specialty and Administrative Services” section in the current Medical Aid Rules and Fee Schedules.

CRNA

Type of Service:

Use Type of Service code “N” with CPT, HCPCS and Local Codes.

CRNA services will be paid at a maximum of ninety percent of the allowed fee that would otherwise be paid to a physician. The only modifiers that are valid for CRNAs are –QX and –QZ (see the “Anesthesia Modifiers” section in the current Medical Aid Rules and Fee Schedules).

CRNA services must be billed on a separate HCFA-1500 form from those of an anesthesiologist, since they each have their own modifiers and provider account numbers. This applies to CRNAs providing solo services as well as team care.

For more information, please refer to WACs 296-23-240 and –245.

Hospital ER/Professional Services

Type of Service:

Use Type of Service code “3” with CPT and HCPCS codes

Hospitals must submit charges for ambulance services and professional services provided by hospital staff physicians on the HCFA-1500 bill form using the provider account number(s) assigned by the department specifically for ambulance services and professional services.

For more information, please refer to Chapter 296-23A “Hospitals” section in the current Medical Aid Rules and Fee Schedules.

Laboratories

Type of Service:

Use Type of Service code “3” with CPT Codes

For more information, please refer to the “Specialty and Administrative Services” section in the current Medical Aid Rules and Fee Schedules.

Naturopath

Type of Service:

Use Type of Service code “D” with HCPCS Codes and Local Codes

For more information, please refer to the “Specialty and Administrative Services” section and WAC 296-23 in the current Medical Aid Rules and Fee Schedule.

Osteopathic Physician

Type of Service:

Use Type of Service code “3” with CPT, HCPCS and Local Codes

Only osteopathic physicians may bill osteopathic manipulative treatment (OMT) using CPT codes.

E/M office visit services are not to be routinely billed in conjunction with OMT. E/M office visit services may be billed in conjunction with OMT only when all the following conditions are met:

- When the E/M service constitutes a significant separately identifiable service that exceeds the usual pre- and post- service work included with OMT.
- There is documentation in a patient’s record which supports the level of E/M billed.
- The E/M service is billed using the -25 modifier. E/M codes billed on the same day as OMT codes without the -25 modifier will not be paid.
- The E/M service may be caused or prompted by the same diagnosis as the OMT service. A separate diagnosis is not required for payment of E/M in addition to OMT services on the same day.

For more information, please refer to the “Washington RBRVS Payment Policies” section in the current Medical Aid Rules and Fee Schedules.

Outpatient Pain Management

Type of Service:

Use Type of Service code “3” with Local Codes 2000M – 2002M

Provider must have a signed contract with the department to provide these services.

The Contractor will bill its usual and customary (U&C) fee, whether it exceeds or is below the approved maximum fees per WAC 296-20-010.

The Contractor must document in the pain clinic program records the type, frequency, length and itemized billed charges for each service provided. The Department will have access to such records upon request.

The Contractor must indicate the period covered in the bill in the box labeled 24A on the HCFA-1500 form.

Panel Examiner

Type of Service:

Use Type of Service “3” with CPT and Local codes

Doctors who wish to perform Independent Medical Examinations for the department or self-insurers providing coverage to workers covered under Title 51 RCW must be approved examiners. Doctors must submit a completed department application to the Provider Review and Education Unit at the Department of Labor and Industries, PO Box 44322, Olympia, WA 98504 and receive the medical director’s approval. Approved examiners will be included on the department’s approved examiners list.

For more information, please refer to Chapter 296-23 in the current Medical Aid Rules and Fee Schedules.

Pathologist

Type of Service:

Use Type of Service code “3” with CPT

Use Type of Service code “9” with HCPCS and Local Codes

For more information, please refer to the “Specialty and Administrative Services” section in the current Medical Aid Rules and Fee Schedules.

Physical Therapist

Type of Service:

Use Type of Service code “P” with CPT and HCPCS Codes

After 12 treatments, you must get authorization from the attending physician and the claims manager.

For more information, please refer to WAC 296-23-220 and the “Washington RBRVS Payment Policies” section in the current Medical Aid Rules and Fee Schedules.

Physician and Physician Clinics

Type of Service:

Use Type of Service code “3” with CPT, HCPCS and Local Codes

For more information, please refer to the “Washington RBRVS Payment Policies” section in the current Medical Aid Rules and Fee Schedules.

Physician Assistants

Type of Service:

Use Type of Service code “3” with CPT Codes

Use Type of Service code “9” with HCPCS and Local Codes

Physician assistants must be certified to qualify for payment. Physician assistants must have valid individual L&I provider account numbers to be paid for services.

Consultation, impairment ratings and administrative or reporting services related to worker’s compensation benefit determinations are not payable to physician assistants. Physician assistant services are paid to the supervising physician or employer at a maximum of ninety percent (90%) of the allowed fee.

Further information about physician assistant services and payment can be found in the Provider Bulletin 99-04 and WAC 296-20-01501.

Podiatric Physician

Type of Service:

Use Type of Service code “3” with CPT Codes

Use Type of Service code “9” with HCPCS and Local Codes

For more information, please refer to the “Washington RBRVS Payment Policies” section in the current Medical Aid Rules and Fee Schedules.

Psychologist

Type of Service:

Use Type of Service code “3” with CPT Codes

A psychiatrist can only be the attending physician on a claim when a psychiatric condition is the **only condition** being treated, and it has been accepted by the department. Psychologists can not be the attending physician and may not certify time loss or rate Permanent Partial Disability under our rules (WAC 296-20-210).

Psychiatric evaluation and treatment services provided by social workers, psychiatric nurse practitioners, and other master’s level counselors are **not covered**, even when delivered under the direct supervision of a clinical psychologist or a psychiatrist. Psychological testing may be administered by staff supervised by a psychiatrist or licensed clinical psychologist. However, the interpretation of testing and preparation of reports must be performed by the psychiatrist or licensed clinical psychologist.

Please refer to WAC 296-21-270, WAC 296-21-280 and “Washington RBRVS Payment Policies” section of the current Medical Aid Rules and Fee Schedules for more information.

Radiologist

Type of Service:

Use Type of Service code “3” with CPT, HCPCS and Local Codes

RT and LT Modifiers

HCPCS modifiers -RT (right side) and -LT (left side) do not affect payment, but may be used with CPT radiology codes (CPT codes 70010 – 79999) to identify duplicate procedures performed on opposite sides of the body.

Consultation Services

CPT code 76140, x-ray consultation, is not covered. For radiology codes where a consultation service is performed, providers should bill the specific x-ray code along with the local modifier -1R.

For more information, please refer to Chapter 296-23-135, -140, -145 and the “Washington RBRVS Payment Policies” section in the current Medical Aid Rules and Fee Schedules.

COMPLETING THE “HCFA-1500” FORM

Completed bill forms **must** be typed or printed and be clearly legible. All of the following boxes **must** be completed to ensure correct bill adjudication. Use the instructions below to complete the HCFA-1500 Health Insurance Claim Form.

The HCFA-1500 is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing Labor and Industries. (The numbered boxes on the claim form are referred to as fields.) Only those fields, which pertain to billing Labor and Industries, are addressed below.

DO NOT WRITE, PRINT, OR STAPLE ANY ATTACHMENTS IN THE BAR CODE AREA AT THE TOP OF THE FORM.

FIELD DESCRIPTION / INSTRUCTIONS FOR COMPLETION

- 1a. **INSURED’S I.D. NO.:** Enter worker’s social security number. This information will assist us in identifying the injured worker’s claim number if the claim number is missing or invalid.
- 2. **PATIENT’S NAME:** Enter injured worker’s last name, first name, and middle initial.
- 3. **PATIENT’S BIRTH DATE:** List the birth date of the worker.
- 5. **PATIENT’S ADDRESS:** Enter worker’s current address.
- 11. **INSURED’S POLICY GROUP OR FECA (Federal Employees Compensation Act) NUMBER:** Enter worker’s L&I claim number. Omission of this number will result in denial of payment.

Claim numbers are alpha-numeric, consisting of seven characters. The letter identifies the funding source which is listed below.

STATE FUND INDUSTRIAL INSURANCE	Claim numbers are six digits, preceded by the letter “B, C, F, G, H, J, K, L, M, N, P, X or Y.”
---------------------------------------	-------------------------------------------------------------------------------------------------

Send bills for State Fund claims to:

Department of Labor and Industries
PO Box 44269
Olympia WA 98504-4269

CRIME VICTIMS	Crime Victim Compensation Program claim numbers are either six digits preceded by a “V”, or five digits preceded by a “VA, VB, VC, VH or VJ”.
------------------	-----------------------------------------------------------------------------------------------------------------------------------------------

Send bills for Crime Victims claims to:

Department of Labor and Industries
Crime Victims Compensation Program
PO Box 44520
Olympia WA 98504-4520

SELF-
INSURANCE

Self-Insurance claim numbers are six digits preceded by an “S, T or W”. Bills for all Self-Insurance claims should be sent directly to the employer or their service company. Department bill forms, self-insured forms, or other forms acceptable to the self-insurer may be used.

14. **DATE OF INJURY/ILLNESS:** The date of injury/illness positively identifies each claim. This is important and must be included. A worker may have several claims; therefore, it is vital the proper claim is identified and charged for services provided.
17. **NAME OF REFERRING PHYSICIAN:** Enter the name of the doctor referring the worker to you, if applicable.
- 17a. **I.D. NUMBER OF REFERRING PHYSICIAN OR OTHER SOURCE:** This information is required if you have not listed ICD9-CM diagnosis codes in box 21 or 24E.
21. **DIAGNOSIS OR NATURE OF INJURY OR ILLNESS:** You may use this space to describe in more detail ICD-9 description or multiple diagnosis. You must fill in specific diagnosis on line 24E for each line item. **Designate left or right side of body, when applicable.**
24. **ENTER ONLY 1 (ONE) SERVICE PER LINE**
- 24a. **DATE OF SERVICE:** Enter numerically the month, day, and year of service (e.g., January 04, 2000 = 010400). When billing for more than one date of service, only consecutive days may be billed on the same line. If dates of service are not consecutive, list each date on a separate line.
- Example: Office visits made on January 3, 4, and 5 may be billed as one entry: 010300 - 010500. A “3” is entered in the units column (24g). However, office calls made on January 2, 4, and 8 should be listed on separate lines. A “1” should be entered in the units column for each date.
- 24b. **PLACE OF SERVICE:** Do not use the Place of Service codes listed on the back of the HCFA-1500 forms not obtained from our department. Enter required 2-digit place of service code. See list of codes in the Place of Service section of this booklet.
- 24c. **TYPE OF SERVICE:** Enter the appropriate Type of Service code. The necessary number or character is contained below. Different types of service require different Type of Service codes. Refer to provider specific instructions

Type of Service

C

3

N

D

P

For which Provider

Chiropractors

Medical Services: Physicians/Physician

Assistants, Psychologist, Osteopathic Physicians, Laboratories, Pathology, Radiology, Outpatient Pain Management Programs, Anesthesiologists

Advanced Registered Nurse Practitioners,

Certified Registered Nurse Anesthetists

Drugless Therapist: Naturopaths

Physical Therapist

- 24d. **PROCEDURE, SERVICE, OR SUPPLY:** Identify the procedure (CPT/HCPCS/Local Code) performed. Enter only one code per line.
- Please Note:** The department does not publish sufficient descriptive CPT and HCPCS information to properly code provided services, since it is already available in these books. Providers and self-insurers must refer to their own copies of these books to determine the appropriate code(s) to use for billing and payment.
- ATTN: All Providers – If service is listed as bundled in the fee schedule, DO NOT include it on the bill form. Codes that are determined as bundled by the department, will be automatically denied.
- CODE MODIFIER:** A modifier indicates a performed service or procedure has been altered by a specific circumstance. A complete list of procedure code modifiers can be found in the RBRVS & Anesthesia Section of the Fee Schedule. Indicate modifier, if applicable, after the procedure code. Example: 20816-80.
- DESCRIPTION OF SERVICES:** Describe services provided, e.g., apply long leg cast. When service is coded “unlisted” in CPT-IV, the treatment or diagnostic study must be fully described.
- 24e. **ICD-9-CM DIAGNOSIS CODE NUMBER:** One code must be recorded in this box for each line item if you do not provide referring physician ID number (in box 17a).
- 24f. **CHARGES:** Enter your usual and customary fee for the procedure billed on this line. (Do NOT bill negative charges)
- 24g. **DAYS OR UNITS:** Enter the total number of units, minutes, or days for the services billed on a line.
25. **FEDERAL TAX I.D. NUMBER:** Required. If the L&I provider account number is missing or invalid, this information helps to identify the correct provider for payment.
26. **PATIENT’S ACCOUNT NO.:** The number you use to identify your patient’s account. This is for your convenience only.
28. **TOTAL CHARGES:** Total of all charges.
31. **SIGNATURE:** Signature may be that of the provider or the person preparing the bill. Regardless of who signs the bill, the provider submitting the bill is responsible for its accuracy. For computer generated bills, the signature may be left blank. The “DATE” is the date the bill is prepared and sent to the department or self-insurer.
32. **NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED:** Physical location where services were rendered.
33. **PHYSICIAN’S, SUPPLIER’S BILLING NAME, ADDRESS, ZIP CODE, AND PHONE #:** Enter the name of the provider providing the services (enter last name first) and current address. If there are any changes in the provider’s address or status, immediately notify Provider Accounts in writing or via fax at the following address/fax number:

Provider Accounts
Department of Labor and Industries
PO Box 44261
Olympia WA 98504-4261
Fax 360-902-4484

PLEASE INCLUDE THE L&I PROVIDER ACCOUNT NUMBER(S) YOU'RE SUBMITTING A CHANGE FOR ON YOUR CORRESPONDENCE.

Indicating a new address on the bill will not change the department's record of your address and could delay payment.

PIN #: Enter the L&I provider account number assigned by L&I for the performing provider of service. Failure to enter your performing providers L&I provider account number will result in the bill being returned and/or denied.

GROUP #: If payment is to be made to a group/clinic or supervising physician (Payee) rather than the provider performing the service, you must enter the group/clinic or supervising physician's (Payee) account number designated by L&I. Include the first two characters of the group/clinic name or the first two characters of the supervising physician's last name. The name must correspond with the account number used.

This applies only to the provider groups where the group/clinic has been assigned a **main L&I provider account number (Payee)** and the members of the group have been assigned individual L&I provider account numbers.

DEPARTMENT OF LABOR AND INDUSTRIES
CLAIMS SECTION
PO BOX 44269
OLYMPIA WA 98504-4269

1. <div>PICA</div>										L&I (ID)										1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)												
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE SEX MM DD YY M F										4. INSURED'S NAME (Last Name, First Name, Middle Initial)												
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other										7. INSURED'S ADDRESS (No., Street)												
CITY					STATE					8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student										CITY					STATE							
ZIP CODE					TELEPHONE (Include Area Code)					11. INSURED'S POLICY GROUP OR FECA NUMBER																						
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) b. AUTO ACCIDENT? PLACE (State) c. OTHER ACCIDENT?										11. INSURED'S POLICY GROUP OR FECA NUMBER												
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. INSURED'S DATE OF BIRTH SEX MM DD YY M F										b. EMPLOYER'S NAME OR SCHOOL NAME												
SEX MM DD YY M F										b. EMPLOYER'S NAME OR SCHOOL NAME										c. INSURANCE PLAN NAME OR PROGRAM NAME												
c. EMPLOYER'S NAME OR SCHOOL NAME										10d. RESERVED FOR LOCAL USE										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.												
d. INSURANCE PLAN NAME OR PROGRAM NAME										12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE – I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED DATE										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE – I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED												
14. DATE OF CURRENT: MM DD YY					ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE										17a. I.D. NUMBER OF REFERRING PHYSICIAN										18. HOSPITALIZATION DATES TO CURRENT SERVICES FROM MM DD YY TO MM DD YY												
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? \$ CHARGES YES NO										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.												
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)										23. PRIOR AUTHORIZATION NUMBER																						
1. 2. 3. 4.																																
24. A					B		C		D					E					F		G		H		I		J		K			
DATE(S) OF SERVICE MM DD YY MM DD YY					PLACE OF SERVICE		Type Of Service		PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER					DIAGNOSIS CODE					\$ CHARGES		Days Or Units		EPST Family Plan		EMG		COB		RESERVED FOR LOCAL USE			
									</																							

PLEASE
DO NOT
STAPLE
IN THIS
AREA



L&I HEALTH INSURANCE CLAIM FORM

DEPARTMENT OF LABOR AND INDUSTRIES
CLAIMS SECTION
PO BOX 44269
OLYMPIA WA 98504-4269

Sample: Anesthesiologist

1. <div>PICA</div>		L&I (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 000-00-0000 (SSN)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, Jane		3. PATIENT'S BIRTH DATE MM DD YY XX XX XX M <input type="checkbox"/> F <input checked="" type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street) 151 Oak Creek Lane		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)	
CITY Morton		STATE WA		CITY	
ZIP CODE 98519		TELEPHONE (Include Area Code) (360) 000-0000		ZIP CODE	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR FECA NUMBER Y 000000 (L & I Claim #)	
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
b. OTHER INSURED'S DATE OF BIRTH SEX MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>				b. EMPLOYER'S NAME OR SCHOOL NAME XYZ Company	
c. EMPLOYER'S NAME OR SCHOOL NAME				c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE – I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE – I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____	
14. DATE OF CURRENT: MM DD YY XX XX XX		ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE Xxxxxx Xxxxxx MD		17a. I.D. NUMBER OF REFERRING PHYSICIAN 0000000		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE				18. HOSPITALIZATION DATES TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) ----- 1. XXX . XX 2. _____ 3. _____ 4. _____				20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES 22. MEDICAID RESUBMISSION CODE 23. PRIOR AUTHORIZATION NUMBER	
24. A DATE(S) OF SERVICE MM DD YY MM DD YY		B PLACE OF SERVICE		C Type Of Service	
D PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E DIAGNOSIS CODE		F \$ CHARGES	
G Days Or Units		H EPSDT Family Plan		I EMG	
J COB		K RESERVED FOR LOCAL USE			
03 01 01 03 01 01		XX		3	
XXXXXX XX		xxx.xx		XX XX	
20 min.					
25. FEDERAL TAX I.D. NUMBER 00-0000000		SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. Optional	
27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ XX XX		29. AMOUNT PAID \$ _____	
30. BALANCE DUE \$ _____		31. PHYSICIAN/SUPPLIER SIGNATURE INCLUDING DEGREES OR CREDENTIALS – (I certify that I understand L&I billing instructions, that information contained on this bill is consistent with those instructions and accurate to the best of my knowledge.) SIGNED VVVVVVVV DATE XX/XX/XX		32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE PROVIDED (If other than home or office)	
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE AND PHONE # Xxxxxx Xxxxxx, MD 3112 Xxxxxx Lane Morton, WA 98519 (XXX) XXX-XXXX PIN # 0000000 GRP # 0000000					

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICES 8/88)
F245-127-000 (3/92)

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

PLEASE
DO NOT
STAPLE
IN THIS
AREA



L&I HEALTH INSURANCE CLAIM FORM

DEPARTMENT OF LABOR AND INDUSTRIES
CLAIMS SECTION
PO BOX 44269
OLYMPIA WA 98504-4269

Sample: Chiropractor

1. PICA		L&I (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM ITEM 1) 000-00-0000 (SSN)																			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, Jane		3. PATIENT'S BIRTH DATE MM DD YY XX XX XX M <input type="checkbox"/> F <input checked="" type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)																			
5. PATIENT'S ADDRESS (No., Street) 151 Oak Creek Lane		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)																			
CITY Morton		STATE WA		CITY																			
ZIP CODE 98519		TELEPHONE (Include Area Code) (360) 000-0000		ZIP CODE																			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		TELEPHONE (Include Area Code) ()																			
a. OTHER INSURED'S POLICY OR GROUP NUMBER		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) <input type="text"/> c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR FECA NUMBER Y 000000 (L & I Claim #)																			
b. OTHER INSURED'S DATE OF BIRTH SEX MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		b. EMPLOYER'S NAME OR SCHOOL NAME XYZ Company																			
c. EMPLOYER'S NAME OR SCHOOL NAME		10d. RESERVED FOR LOCAL USE		c. INSURANCE PLAN NAME OR PROGRAM NAME																			
d. INSURANCE PLAN NAME OR PROGRAM NAME		12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE - I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.																			
14. DATE OF CURRENT: MM DD YY XX XX XX		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE - I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____																			
ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY		18. HOSPITALIZATION DATES TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																			
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE Xxxxxx Xxxxxx MD		17a. I.D. NUMBER OF REFERRING PHYSICIAN 0000000		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES																			
19. RESERVED FOR LOCAL USE		21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) ↓ 1. XXX . XX 2. _____ 3. _____ 4. _____		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER																			
24. A DATE(S) OF SERVICE MM DD YY MM DD YY		B PLACE OF SERVICE		C Type of Service		D PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E DIAGNOSIS CODE		F \$ CHARGES		G Days or Units		H EPSDT Family Plan		I EMG		J COB		K RESERVED FOR LOCAL USE			
03 01 01 03 01 01		XX		C		XXXXXX XX		xxx.xx		XX XX		1											
03 01 01 03 01 01		XX		C		XXXXXX XX		xxx.xx		XX XX		1											
25. FEDERAL TAX I.D. NUMBER 00-0000000		SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. Optional		27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ XX XX		29. AMOUNT PAID \$		30. BALANCE DUE \$											
31. PHYSICIAN/SUPPLIER SIGNATURE INCLUDING DEGREES OR CREDENTIALS - (I certify that I understand L&I billing instructions, that information contained on this bill is consistent with those instructions and accurate to the best of my knowledge.) SIGNED XXXXXXXXXX DATE XX/XX/XX				32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE PROVIDED (If other than home or office)				33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE AND PHONE # Xxxxxxx Xxxxxxx, DC 3112 Xxxxxxx Lane Morton, WA 98519 (XXX) XXX-XXXX PIN # 0000000 GRP # 0000000															

PLEASE
DO NOT
STAPLE
IN THIS
AREA



L&I HEALTH INSURANCE CLAIM FORM

DEPARTMENT OF LABOR AND INDUSTRIES
CLAIMS SECTION
PO BOX 44269
OLYMPIA WA 98504-4269

Sample: Hospital ER/Prof Svcs

PICA		L&I (ID)		PICA																	
1. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, Jane		3. PATIENT'S BIRTH DATE MM DD YY XX XX XX M <input type="checkbox"/> F <input checked="" type="checkbox"/>		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 000-00-0000 (SSN)																	
5. PATIENT'S ADDRESS (No., Street) 151 Oak Creek Lane		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)																	
CITY Morton		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time <input type="checkbox"/> Student <input type="checkbox"/> Part-Time <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)																	
STATE WA		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		CITY ZIP CODE TELEPHONE (Include Area Code) ()																	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		11. INSURED'S POLICY GROUP OR FECA NUMBER Y 000000 (L & I Claim #)		11. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>																	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. EMPLOYER'S NAME OR SCHOOL NAME XYZ Company		b. EMPLOYER'S NAME OR SCHOOL NAME																	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		c. INSURANCE PLAN NAME OR PROGRAM NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME																	
c. EMPLOYER'S NAME OR SCHOOL NAME		10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.																	
d. INSURANCE PLAN NAME OR PROGRAM NAME		12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE - I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE - I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____																	
14. DATE OF CURRENT: <input type="checkbox"/> ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY XX XX XX		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE Xxxxxx Xxxxxx MD		17a. I.D. NUMBER OF REFERRING PHYSICIAN 0000000		18. HOSPITALIZATION DATES TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) 1. XXX . XX 2. _____ 3. _____ 4. _____		23. PRIOR AUTHORIZATION NUMBER		23. PRIOR AUTHORIZATION NUMBER																	
24. A DATE(S) OF SERVICE MM DD YY MM DD YY		B PLACE OF SERVICE		C Type of Service		D PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E DIAGNOSIS CODE		F \$ CHARGES		G Days or Units		H EPSDT Family Plan		I EMG		J COB		K RESERVED FOR LOCAL USE	
03 01 01 03 01 01		XX		3		XXXXXX		xxx.xx		XX XX		1									
03 01 01 03 01 01		XX		3		XXXXXX		xxx.xx		XX XX		1									
25. FEDERAL TAX I.D. NUMBER 00-0000000		SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. Optional		27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ XX XX		29. AMOUNT PAID \$		30. BALANCE DUE \$									
31. PHYSICIAN/SUPPLIER SIGNATURE INCLUDING DEGREES OR CREDENTIALS - (I certify that I understand L&I billing instructions, that information contained on this bill is consistent with those instructions and accurate to the best of my knowledge.) SIGNED VVVVVVVV DATE XX/XX/XX		32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE PROVIDED (If other than home or office)		33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE AND PHONE # Pacific Laboratories 3112 Xxxxxx Lane Morton, WA 98519 (XXX) XXX-XXXX PIN # 0000000 GRP # 0000000																	
(APPROVED BY AMA COUNCIL ON MEDICAL SERVICES 8/88) F245-127-000 (3/92)																					

PLEASE
DO NOT
STAPLE
IN THIS
AREA



L&I HEALTH INSURANCE CLAIM FORM

DEPARTMENT OF LABOR AND INDUSTRIES
CLAIMS SECTION
PO BOX 44269
OLYMPIA WA 98504-4269

Sample: Laboratory

1. PICA		L&I (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 000-00-0000 (SSN)																	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, Jane		3. PATIENT'S BIRTH DATE MM DD YY XX XX XX M <input type="checkbox"/> F <input checked="" type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)																	
5. PATIENT'S ADDRESS (No., Street) 151 Oak Creek Lane		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)																	
CITY Morton		STATE WA		CITY																	
ZIP CODE 98519		TELEPHONE (Include Area Code) (360) 000-0000		STATE																	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		ZIP CODE																	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		TELEPHONE (Include Area Code) ()																	
b. OTHER INSURED'S DATE OF BIRTH SEX MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		11. INSURED'S POLICY GROUP OR FECA NUMBER Y 000000 (L & I Claim #)		a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>																	
c. EMPLOYER'S NAME OR SCHOOL NAME		b. EMPLOYER'S NAME OR SCHOOL NAME XYZ Company		c. INSURANCE PLAN NAME OR PROGRAM NAME																	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.																	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE - I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE - I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____																	
14. DATE OF CURRENT: MM DD YY XX XX XX		ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY																	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE Xxxxxx Xxxxxx MD		17a. I.D. NUMBER OF REFERRING PHYSICIAN 0000000		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																	
19. RESERVED FOR LOCAL USE		18. HOSPITALIZATION DATES TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES																	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) ----- 1. XXX . XX 2. _____ 3. _____ 4. _____		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.		23. PRIOR AUTHORIZATION NUMBER																	
24. A		B		C		D		E		F		G		H		I		J		K	
DATE(S) OF SERVICE MM DD YY MM DD YY		PLACE OF SERVICE		Type Of Service		PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		DIAGNOSIS CODE		\$ CHARGES		Days Or Units		EPST Family Plan		EMG		COB		RESERVED FOR LOCAL USE	
03 01 01 03 01 01		XX		3		XXXXXX		xxx.xx		XX XX		1									
03 01 01 03 01 01		XX		3		XXXXXX		xxx.xx		XX XX		1									
25. FEDERAL TAX I.D. NUMBER 00-0000000		SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. Optional		27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ XX XX		29. AMOUNT PAID \$		30. BALANCE DUE \$									
31. PHYSICIAN/SUPPLIER SIGNATURE INCLUDING DEGREES OR CREDENTIALS - (I certify that I understand L&I billing instructions, that information contained on this bill is consistent with those instructions and accurate to the best of my knowledge.) SIGNED WVVVVVVV DATE XX/XX/XX		32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE PROVIDED (If other than home or office)		33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE AND PHONE # Pacific Laboratories 3112 Xxxxxx Lane Morton, WA 98519 (XXX) XXX-XXXX PIN # 0000000 GRP # 0000000																	

DEPARTMENT OF LABOR AND INDUSTRIES
CLAIMS SECTION
PO BOX 44269
OLYMPIA WA 98504-4269

[illegible]

PLEASE
DO NOT
STAPLE
IN THIS
AREA



L&I HEALTH INSURANCE CLAIM FORM

DEPARTMENT OF LABOR AND INDUSTRIES
CLAIMS SECTION
PO BOX 44269
OLYMPIA WA 98504-4269

Sample: Osteopathic

1. PICA		L&I (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 000-00-0000 (SSN)																	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, Jane		3. PATIENT'S BIRTH DATE MM DD YY XX XX XX M <input type="checkbox"/> F <input checked="" type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)																	
5. PATIENT'S ADDRESS (No., Street) 151 Oak Creek Lane		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)																	
CITY Morton		STATE WA		CITY																	
ZIP CODE 98519		TELEPHONE (Include Area Code) (360) 000-0000		STATE																	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		ZIP CODE																	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		TELEPHONE (Include Area Code) ()																	
b. OTHER INSURED'S DATE OF BIRTH SEX MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		11. INSURED'S POLICY GROUP OR FECA NUMBER Y 000000 (L & I Claim #)		a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>																	
c. EMPLOYER'S NAME OR SCHOOL NAME		b. EMPLOYER'S NAME OR SCHOOL NAME XYZ Company		c. INSURANCE PLAN NAME OR PROGRAM NAME																	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.																	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE - I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE - I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____																	
14. DATE OF CURRENT: MM DD YY XX XX XX		ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY																	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE Xxxxxx Xxxxxx MD		17a. I.D. NUMBER OF REFERRING PHYSICIAN 0000000		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																	
19. RESERVED FOR LOCAL USE		18. HOSPITALIZATION DATES TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO																	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) ----- 1. XXX . XX 2. _____ 3. _____ 4. _____		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. _____		23. PRIOR AUTHORIZATION NUMBER																	
24. A		B		C		D		E		F		G		H		I		J		K	
DATE(S) OF SERVICE MM DD YY MM DD YY		PLACE OF SERVICE		Type Of Service		PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		DIAGNOSIS CODE		\$ CHARGES		Days Of Units		EPST Family Plan		EMG		COB		RESERVED FOR LOCAL USE	
03 01 01 03 01 01		XX		3		XXXXXX XX		xxx.xx		XX XX		1									
25. FEDERAL TAX I.D. NUMBER 00-0000000		SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. Optional		27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ XX XX		29. AMOUNT PAID \$		30. BALANCE DUE \$									
31. PHYSICIAN/SUPPLIER SIGNATURE INCLUDING DEGREES OR CREDENTIALS - (I certify that I understand L&I billing instructions, that information contained on this bill is consistent with those instructions and accurate to the best of my knowledge.) SIGNED VVVVVVVV DATE XX/XX/XX				32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE PROVIDED (If other than home or office)				33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE AND PHONE # Xxxxx Xxxxx, DO 3112 Xxxxxx Lane Morton, WA 98519 (XXX) XXX-XXXX PIN # 0000000 GRP # 0000000													
(APPROVED BY AMA COUNCIL ON MEDICAL SERVICES 8/88) F245-127-000 (3/92)										FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500											

PLEASE
DO NOT
STAPLE
IN THIS
AREA



L&I HEALTH INSURANCE CLAIM FORM

DEPARTMENT OF LABOR AND INDUSTRIES
CLAIMS SECTION
PO BOX 44269
OLYMPIA WA 98504-4269

Sample: Outpatient Pain Mgmt Pgm

1. PICA		L&I (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 000-00-0000 (SSN)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, Jane		3. PATIENT'S BIRTH DATE MM DD YY XX XX XX M <input type="checkbox"/> F <input checked="" type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street) 151 Oak Creek Lane		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)	
CITY Morton		STATE WA		CITY	
ZIP CODE 98519		TELEPHONE (Include Area Code) (360) 000-0000		STATE	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		ZIP CODE	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		TELEPHONE (Include Area Code) ()	
b. OTHER INSURED'S DATE OF BIRTH SEX MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		11. INSURED'S POLICY GROUP OR FECA NUMBER Y 000000 (L & I Claim #)		a. INSURED'S DATE OF BIRTH SEX MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>	
c. EMPLOYER'S NAME OR SCHOOL NAME		b. EMPLOYER'S NAME OR SCHOOL NAME XYZ Company		c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE - I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE - I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____	
14. DATE OF CURRENT: MM DD YY XX XX XX		ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE Xxxxxx Xxxxxx MD		17a. I.D. NUMBER OF REFERRING PHYSICIAN 0000000		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE		18. HOSPITALIZATION DATES TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) ----- 1. XXX . XX 2. _____ 3. _____ 4. _____		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.		23. PRIOR AUTHORIZATION NUMBER	
24. A		B		C	
DATE(S) OF SERVICE MM DD YY MM DD YY		PLACE OF SERVICE		Type Of Service	
PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		DIAGNOSIS CODE		\$ CHARGES	
03 01 01 03 01 01		XX 3		XXXXX xxx.xx	
03 30 01 04 28 01		XX 3		XXXXX xxx.xx	
25. FEDERAL TAX I.D. NUMBER 00-0000000		SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. Optional	
27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ XXXX XX		29. AMOUNT PAID \$	
30. BALANCE DUE \$		31. PHYSICIAN/SUPPLIER SIGNATURE INCLUDING DEGREES OR CREDENTIALS - (I certify that I understand L&I billing instructions, that information contained on this bill is consistent with those instructions and accurate to the best of my knowledge.) SIGNED VVVVVVVV DATE XX/XX/XX		32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE PROVIDED (If other than home or office)	
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE AND PHONE # Outpatient Pain Program 3112 Xxxxxx Lane Morton, WA 98519 (XXX) XXX-XXXX PIN # 0000000 GRP # 0000000					

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICES 8/88)
F245-127-000 (3/92)

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

DEPARTMENT OF LABOR AND INDUSTRIES
CLAIMS SECTION
PO BOX 44269
OLYMPIA WA 98504-4269

[illegible]

PLEASE
DO NOT
STAPLE
IN THIS
AREA



L&I HEALTH INSURANCE CLAIM FORM

DEPARTMENT OF LABOR AND INDUSTRIES
CLAIMS SECTION
PO BOX 44269
OLYMPIA WA 98504-4269

Sample: Pathology

1. PICA		L&I (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 000-00-0000 (SSN)																	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, Jane		3. PATIENT'S BIRTH DATE MM DD YY XX XX XX M <input type="checkbox"/> F <input checked="" type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)																	
5. PATIENT'S ADDRESS (No., Street) 151 Oak Creek Lane		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)																	
CITY Morton		STATE WA		CITY																	
ZIP CODE 98519		TELEPHONE (Include Area Code) (360) 000-0000		STATE																	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		ZIP CODE																	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		TELEPHONE (Include Area Code) ()																	
b. OTHER INSURED'S DATE OF BIRTH SEX MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		11. INSURED'S POLICY GROUP OR FECA NUMBER Y 000000 (L & I Claim #)		a. INSURED'S DATE OF BIRTH SEX MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>																	
c. EMPLOYER'S NAME OR SCHOOL NAME		b. EMPLOYER'S NAME OR SCHOOL NAME XYZ Company		c. INSURANCE PLAN NAME OR PROGRAM NAME																	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.																	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE - I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE - I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____																	
14. DATE OF CURRENT: MM DD YY XX XX XX		ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY																	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE Xxxxxx Xxxxxx MD		17a. I.D. NUMBER OF REFERRING PHYSICIAN 0000000		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																	
19. RESERVED FOR LOCAL USE		18. HOSPITALIZATION DATES TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO																	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) ----- 1. XXX . XX 2. _____ 3. _____ 4. _____		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. _____		23. PRIOR AUTHORIZATION NUMBER																	
24. A		B		C		D		E		F		G		H		I		J		K	
DATE(S) OF SERVICE MM DD YY MM DD YY		PLACE OF SERVICE		Type Of Service		PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		DIAGNOSIS CODE		\$ CHARGES		Days Or Units		EPST Family Plan		EMG		COB		RESERVED FOR LOCAL USE	
03 01 01 03 01 01		XX		3		XXXXXX		xxx.xx		XX XX		1									
03 01 01 03 01 01		XX		3		XXXXXX		xxx.xx		XX XX		1									
25. FEDERAL TAX I.D. NUMBER 00-0000000		SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. Optional		27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ XX XX		29. AMOUNT PAID \$		30. BALANCE DUE \$									
31. PHYSICIAN/SUPPLIER SIGNATURE INCLUDING DEGREES OR CREDENTIALS - (I certify that I understand L&I billing instructions, that information contained on this bill is consistent with those instructions and accurate to the best of my knowledge.) SIGNED VVVVVVVV DATE XX/XX/XX				32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE PROVIDED (If other than home or office)				33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE AND PHONE # Pathology NW Inc 3112 Xxxxxx Lane Morton, WA 98519 (XXX) XXX-XXXX PIN # 0000000 GRP # 0000000													
(APPROVED BY AMA COUNCIL ON MEDICAL SERVICES 8/88) F245-127-000 (3/92)												FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500									

PLEASE
DO NOT
STAPLE
IN THIS
AREA



L&I HEALTH INSURANCE CLAIM FORM

DEPARTMENT OF LABOR AND INDUSTRIES
CLAIMS SECTION
PO BOX 44269
OLYMPIA WA 98504-4269

Sample: Physical Therapy

1. PICA		L&I (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 000-00-0000 (SSN)																	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, Jane		3. PATIENT'S BIRTH DATE MM DD YY XX XX XX M <input type="checkbox"/> F <input checked="" type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)																	
5. PATIENT'S ADDRESS (No., Street) 151 Oak Creek Lane		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)																	
CITY Morton		STATE WA		CITY																	
ZIP CODE 98519		TELEPHONE (Include Area Code) (360) 000-0000		STATE																	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		11. INSURED'S POLICY GROUP OR FECA NUMBER Y 000000 (L & I Claim #)																	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>																	
b. OTHER INSURED'S DATE OF BIRTH SEX MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>				b. EMPLOYER'S NAME OR SCHOOL NAME XYZ Company																	
c. EMPLOYER'S NAME OR SCHOOL NAME				c. INSURANCE PLAN NAME OR PROGRAM NAME																	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.																	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE - I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE - I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____																	
14. DATE OF CURRENT: MM DD YY XX XX XX		ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE Xxxxxx Xxxxxx MD		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY 0000000		18. HOSPITALIZATION DATES TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																	
19. RESERVED FOR LOCAL USE				20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO																	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) ----- 1. XXX . XX 2. _____ 3. _____ 4. _____				22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER																	
24. A		B		C		D		E		F		G		H		I		J		K	
DATE(S) OF SERVICE MM DD YY MM DD YY		PLACE OF SERVICE		Type Of Service		PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		DIAGNOSIS CODE		\$ CHARGES		Days Of Units		EPST Family Plan		EMG		COB		RESERVED FOR LOCAL USE	
03 01 01 03 01 01		XX		P		XXXXXX		xxx.xx		XX XX		1									
03 01 01 03 01 01		XX		P		XXXXXX		xxx.xx		XX XX		1									
25. FEDERAL TAX I.D. NUMBER 00-0000000		SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. Optional		27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ XX XX		29. AMOUNT PAID \$		30. BALANCE DUE \$									
31. PHYSICIAN/SUPPLIER SIGNATURE INCLUDING DEGREES OR CREDENTIALS - (I certify that I understand L&I billing instructions, that information contained on this bill is consistent with those instructions and accurate to the best of my knowledge.) SIGNED VVVVVVVV DATE XX/XX/XX				32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE PROVIDED (If other than home or office)				33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE AND PHONE # Xxxxx Xxxxx, PT 3112 Xxxxx Lane Morton, WA 98519 (XXX) XXX-XXXX PIN # 0000000 GRP # 0000000													

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICES 8/88)
F245-127-000 (3/92)

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

DEPARTMENT OF LABOR AND INDUSTRIES
CLAIMS SECTION
PO BOX 44269
OLYMPIA WA 98504-4269

1. PICA		L&I (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 000-00-0000 (SSN)							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, Jane		3. PATIENT'S BIRTH DATE SEX MM DD YY XX XX XX M F <input checked="" type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)							
5. PATIENT'S ADDRESS (No., Street) 151 Oak Creek Lane		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)							
CITY Morton		STATE WA		CITY STATE							
ZIP CODE 98519		TELEPHONE (Include Area Code) (360) 000-0000		ZIP CODE TELEPHONE (Include Area Code) ()							
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. RESERVED FOR LOCAL USE		11. INSURED'S POLICY GROUP OR FECA NUMBER Y 000000 (L & I Claim #) a. INSURED'S DATE OF BIRTH SEX MM DD YY M F <input type="checkbox"/> b. EMPLOYER'S NAME OR SCHOOL NAME XYZ Company c. INSURANCE PLAN NAME OR PROGRAM NAME							
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE – I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE – I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____							
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY							
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE Xxxxxx Xxxxxx MD		17a. I.D. NUMBER OF REFERRING PHYSICIAN 0000000		18. HOSPITALIZATION DATES TO CURRENT SERVICES FROM MM DD YY TO MM DD YY							
19. RESERVED FOR LOCAL USE				20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) ----- 1. XXX . XX 2. _____ 3. _____ 4. _____				22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER							
24. A		B	C	D	E	F	G	H	I	J	K
DATE(S) OF SERVICE MM DD YY MM DD YY		PLACE OF SERVICE	Type of Service	PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	DIAGNOSIS CODE	\$ CHARGES	Days Or Units	EPSTD Family Plan	EMG	COB	RESERVED FOR LOCAL USE
03 01 01 03 01 01		XX	3	XXXXX XX	xxx.xx	XX XX	1				
03 01 01 03 01 01		XX	3	XXXXX XX	xxx.xx	XX XX	1				
25. FEDERAL TAX I.D. NUMBER SSN EIN 00-0000000 <input type="checkbox"/> <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. Optional		27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ XX XX		29. AMOUNT PAID \$		30. BALANCE DUE \$	
31. PHYSICIAN/SUPPLIER SIGNATURE INCLUDING DEGREES OR CRED ENTIALS – (I certify that I understand L&I billing instructions, that information contained on this bill is consistent with those instructions and accurate to the best of my knowledge.) SIGNED VVVVVVVV DATE XX/XX/XX		32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE PROVIDED (If other than home or office)		33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE AND PHONE # Xxxxx Xxxxx, MD/Medical Clinic 3112 Xxxxxx Lane Morton, WA 98519 (XXX) XXX-XXXX PIN # 0000000 GRP # 0000000							

DEPARTMENT OF LABOR AND INDUSTRIES
CLAIMS SECTION
PO BOX 44269
OLYMPIA WA 98504-4269

1. PICA		L&I (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM ITEM 1) 000-00-0000 (SSN)																	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, Jane		3. PATIENT'S BIRTH DATE SEX MM DD YY XX XX XX M F <input checked="" type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)																	
5. PATIENT'S ADDRESS (No., Street) 151 Oak Creek Lane		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)																	
CITY Morton		STATE WA		CITY STATE																	
ZIP CODE 98519		TELEPHONE (Include Area Code) (360) 000-0000		ZIP CODE TELEPHONE (Include Area Code) ()																	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) <input type="text"/> c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR FECA NUMBER Y 000000 (L & I Claim #)																	
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. INSURED'S DATE OF BIRTH SEX MM DD YY M F <input type="checkbox"/>																	
b. OTHER INSURED'S DATE OF BIRTH SEX MM DD YY M F <input type="checkbox"/>				b. EMPLOYER'S NAME OR SCHOOL NAME XYZ Company																	
c. EMPLOYER'S NAME OR SCHOOL NAME				c. INSURANCE PLAN NAME OR PROGRAM NAME																	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.																	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE – I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE – I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____																	
14. DATE OF CURRENT: MM DD YY XX XX XX ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE Xxxxxx Xxxxxx MD		17a. I.D. NUMBER OF REFERRING PHYSICIAN 0000000		18. HOSPITALIZATION DATES TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																	
19. RESERVED FOR LOCAL USE				20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES																	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) 1. XXX . XX 3. _____ 2. _____ 4. _____				22. MEDICAD RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER																	
24. A		B		C		D		E		F		G		H		I		J		K	
DATE(S) OF SERVICE MM DD YY MM DD YY		PLACE OF SERVICE		Type Of Service		PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		DIAGNOSIS CODE		\$ CHARGES		Days Or Units		EPSDT Family Plan		EMG		COB		RESERVED FOR LOCAL USE	
03 01 01 03 01 01		XX		3		XXXXXX XX		XXX.XX		XX XX		1									
25. FEDERAL TAX I.D. NUMBER 00-0000000		SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. Optional		27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ XX XX		29. AMOUNT PAID \$ 		30. BALANCE DUE \$ 									
31. PHYSICIAN/SUPPLIER SIGNATURE INCLUDING DEGREES OR CREDENTIALS – (I certify that I understand L&I billing instructions, that information contained on this bill is consistent with those instructions and accurate to the best of my knowledge.) SIGNED WWWWWWW DATE XX/XX/XX				32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE PROVIDED (If other than home or office)				33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE AND PHONE # Xxxxx Xxxxx, PA 3112 Xxxxxx Lane Morton, WA 98519 (XXX) XXX-XXXX PIN # 0000000 GRP # 0000000													

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICES 8/88)
F245-127-000 (3/92)

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

DEPARTMENT OF LABOR AND INDUSTRIES
CLAIMS SECTION
PO BOX 44269
OLYMPIA WA 98504-4269

[illegible]

PLEASE
DO NOT
STAPLE
IN THIS
AREA



L&I HEALTH INSURANCE CLAIM FORM

DEPARTMENT OF LABOR AND INDUSTRIES
CLAIMS SECTION
PO BOX 44269
OLYMPIA WA 98504-4269

Sample: Radiology

1. <div>PICA</div>		L&I (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 000-00-0000 (SSN)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, Jane		3. PATIENT'S BIRTH DATE MM DD YY XX XX XX M <input type="checkbox"/> F <input checked="" type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street) 151 Oak Creek Lane		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)	
CITY Morton		STATE WA		CITY	
ZIP CODE 98519		TELEPHONE (Include Area Code) (360) 000-0000		STATE	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		ZIP CODE	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		TELEPHONE (Include Area Code) ()	
b. OTHER INSURED'S DATE OF BIRTH SEX MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		11. INSURED'S POLICY GROUP OR FECA NUMBER Y 000000 (L & I Claim #)		a. INSURED'S DATE OF BIRTH SEX MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>	
c. EMPLOYER'S NAME OR SCHOOL NAME		b. EMPLOYER'S NAME OR SCHOOL NAME XYZ Company		c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE – I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE – I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____	
14. DATE OF CURRENT: MM DD YY XX XX XX		ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE Xxxxxx Xxxxxx MD		17a. I.D. NUMBER OF REFERRING PHYSICIAN 0000000		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE		18. HOSPITALIZATION DATES TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) ----- 1. XXX . XX 2. _____ 3. _____ 4. _____		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.		23. PRIOR AUTHORIZATION NUMBER	
24. A		B		C	
DATE(S) OF SERVICE MM DD YY MM DD YY		PLACE OF SERVICE		Type Of Service	
PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		DIAGNOSIS CODE		\$ CHARGES	
03 01 01 03 01 01		XX 3		XXXXX XX xxx.xx XX XX 1	
03 01 01 03 01 01		XX 3		XXXXX XX xxx.xx XX XX 1	
25. FEDERAL TAX I.D. NUMBER 00-0000000		SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. Optional	
31. PHYSICIAN/SUPPLIER SIGNATURE INCLUDING DEGREES OR CREDENTIALS – (I certify that I understand L&I billing instructions, that information contained on this bill is consistent with those instructions and accurate to the best of my knowledge.) SIGNED VVVVVVVVVV DATE XX/XX/XX		27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ XX XX	
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE PROVIDED (If other than home or office)		29. AMOUNT PAID \$		30. BALANCE DUE \$	
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE AND PHONE # Jones Radiology Inc 3112 Xxxxxx Lane Morton, WA 98519 (XXX) XXX-XXXX PIN # 0000000 GRP # 0000000					

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

REBILLS

REBILLS should be submitted when:

Your TOTAL BILL has been denied.

Your bill was sent in over 60 days ago and is not yet showing up on your Remittance Advice

You are **required** to REBILL: (WAC 296-20-125)

- For TOTAL BILLS denied because the claim was closed and the claim has now been reopened
- For TOTAL BILLS denied because the claim was first rejected and the claim has now been allowed.
- For TOTAL BILLS denied because a diagnosis was at first not allowed and the diagnosis has now been allowed

*Rebills must be received at the department **within one year of the date the final order was issued** which reopened or allowed the claim or diagnosis.*

A rebill should be identical to the original bill: same charges, codes and dates of service.

Rebills should be submitted on new ORIGINAL bill forms. We cannot process photocopies or facsimiles.

ADJUSTMENTS

A **“Providers Request for Adjustment” form (F245-183-000)** should be submitted to correct an incorrect field on a bill that has **already processed and partially paid**.

Enter the workers name (field 1), their claim number as it appears on your REMITTANCE ADVICE (field 2), the correct claim number if applicable (field 3), the providers name and address (field 4), the ICN (internal control number) of the bill (field 5) as it appears on your REMITTANCE ADVICE (see example headings below for location of the ICN as it appears on your REMITTANCE ADVICE), the performing providers L&I provider number (field 6) and L&I payee number (field 7), if applicable.

Claim #	Name	I	Patient Acct#	ICN	Service From	Dates To	Unit	Procedure	Billed Charge
P000000	XXXXXXX	X	XXXXXXXXXX	00103625045000200	121300	121700	1	XXXXX	XX.XX

In the body of the form (field 8) complete only those line item fields that have been paid or denied incorrectly due to incorrect information. Enter only the corrected information in the line item fields corresponding to the line item fields on your bill as it appears on your REMITTANCE ADVICE.

EXAMPLE:

You billed one unit of service on line one but four units were actually completed and should be payable. You've only been paid for one unit. Everything else on the bill is correct. In field 8, on line one of the adjustment form, enter '4' in the 'unit' field. After the adjustment processes you will receive payment for the three units previously unpaid.

Please attach to the adjustment form a copy of your ORIGINAL BILL and a copy of the page of your REMITTANCE ADVICE where your paid bill appears.

Request for Reconsideration on **adjustments initiated by the department:**

Per legal notice on your REMITTANCE ADVICE, a request for reconsideration of a decreased adjusted payment must be made in writing within 20 days of receipt of payment.

The basis for the request for reconsideration must be other than an objection to the payment amount established by the departments fee schedule.

All supporting documentation relevant to the reconsideration request should be submitted with the request.

Note:

DO NOT SUBMIT an adjustment or a rebill for a bill that is reported “in process” on your Remittance Advice. If the bill remains in the “in process” status for **over 60 days**, call our Provider Hotline at 1-800-848-0811. For bills “in process” **under 60 days** you may access the Claim Information Line by calling 1-800-831-5227. Once you access the ‘in process’ bill information, you may choose the ‘zero’ option to be connected to the bill payment section.

Adjustments will appear as the last item on the Remittance Advice as follows:

(See sample RA on next page)

Your original bill will be reprinted, appearing as a credit for the amount previously paid, (e.g., \$100.00 - CRE).

Your adjustment will usually appear immediately following the credit of your bill.

If an additional payment is allowed, the total amount allowed for the bill will be reported (e.g., \$125.00). The “adjusted payment” will be paid in the warrant (e.g., \$25.00).

If no additional fee is allowable, the amount of the adjustment will be equal to the credit of the previous payment (e.g., \$100.00).

If the original payment is being recouped, the total amount allowed for the bill will be reported (e.g., \$0.00). The “adjusted payment” will recoup the original amount of the bill.

NO STAPLES IN
BAR CODE AREA

Department of Labor and Industries
PO Box 44267
Olympia WA 98504-4267

PROVIDER'S REQUEST FOR ADJUSTMENT

DO NOT
WRITE IN
SPACE

>

CHECK @
ONE

☐
☐
☐

TOTAL OVERPAYMENT
PARTIAL OVERPAYMENT
UNDERPAYMENT

Please type or print in dark ink

ENTER DATA FROM ORIGINAL REMITTANCE ADVICE				INSTRUCTIONS ARE ENCLOSED			
1) WORKERS NAME (Last, First, Middle)				2) CLAIM NUMBER ON REMIT ADVICE		3) CORRECT CLAIM NUMBER	
4) PROVIDER NAME AND ADDRESS				5) ICN NUMBER ON REMITTANCE ADVICE			
				6) PROVIDER NUMBER			
				7) PAYEE NUMBER			

COMPLETE ONLY THOSE LINE ITEMS PAID/DENIED IN ERROR - ENTER ONLY CORRECTED INFORMATION											
8) Line Item #	a) From/to Date of Service or Covered Dates	b) P O S	c) T O S	d) Procedure Code/ Revenue Code/NDC	e) CODE MOD	f) ICD-9-CM Diagnosis/ Side of Body	g) Tooth Number	h) Charge	i) Days/ Units/ Quantity	j) Days Supply	k) Description
01											
02											
03											
04											
05											
06											
07											
08											
09											
10											
11											
12											
13											
14											

9. OTHER REMARKS/JUSTIFICATIONS/SPECIAL CIRCUMSTANCES - ATTACH REQUIRED REPORTS - EXPLAIN FULLY

DATE	SIGNATURE OF PERSON COMPLETING FORM	PHONE NUMBER ()
------	-------------------------------------	---------------------

ADJUSTMENT REQUEST FORM

THE ADJUSTMENT REQUEST FORM MAY BE USED IN THE FOLLOWING INSTANCES:

TOTAL OVERPAYMENT ---- Entire bill was paid in error. You may either submit an Adjustment Request Form and we will process a credit to recover our payment; OR you may issue a refund check directly to the Department. If a refund is submitted, you must attach a copy of the remittance advice indicating the ICN overpaid. Submit refunds to:

**Cashiers Office
Department of Labor and Industries
PO Box 44835
Olympia WA 98504-4835**

PARTIAL OVERPAYMENT --- A portion of the bill was overpaid. Complete Adjustment Request Form with correct information, including date of service, for the procedures/items paid incorrectly.

UNDERPAYMENT ----- If a bill has been underpaid in error, the Adjustment Request Form must be completed with all pertinent information including date of service. Corrections or justification and/or reports must be included.

This form may **NOT** be used for:

Bills returned to you by the Department **OR** totally denied bill. New bill must be submitted.

INSTRUCTIONS FOR COMPLETING ADJUSTMENT REQUEST

Submit only one form for each ICN (Internal Control Number).

Attach a copy of remittance advice and original bill.

1. **WORKER'S NAME:** Clearly print injured worker's full name.
2. **CLAIM NUMBER ON REMITTANCE ADVICE:** Enter the 7-digit number found in the Claim Number column on the remittance advice.
3. **CORRECT CLAIM NUMBER:** Claim number these services should be paid under.
4. **PROVIDER NAME AND ADDRESS:** Enter the name and address of the provider providing the service. Include telephone number.
5. **ICN NUMBER:** Enter the 17-digit number found in the ICN column to identify the bill submitted.
6. **PROVIDER NUMBER:** Enter the Labor and Industries provider account number for the provider of service as it appears on the remittance advice.
7. **PAYEE NUMBER:** Enter the Labor and Industries payee provider account number if payee was **different** than the provider of service.
8. **SERVICE ITEMIZATION:** Complete only for those line items to be corrected. Enter corrected information on line item number corresponding to line item number on original bill.
 - a. **From/to Date of Service or Covered Dates:** Date of Service, from and to date if date span previously billed. Admit and discharge date for hospital bill.
 - b. **Place of Service:** (POS) Two digit code identifying the place of service was performed.
 - c. **Type of Service:** (TOS) One digit code identifying the general type of service performed.
 - d. **Procedure Code/Revenue Code/NDC:** Identify correct procedure, hospital service or national drug code.
 - e. **Code Mod:** Modifier used to identify special circumstances for a service or procedure.
 - f. **ICD-9-CM Diagnosis/Side of Body:** ICD-9-CM diagnosis code for condition treated. Designate left or right side of body where applicable.
 - g. **Tooth Number:** For dental services only. Enter the two digit identification number of the specific tooth number treated (e.g., 08).
 - h. **Charge:** Total of charges for services provided this line.
 - i. **Days/Units/Quantity:** Total days stay for hospital accommodation codes, unit of service for procedure (time units, hours, miles, etc.), number of items (tablets, milliliters, etc.).
 - j. **Days Supply:** Total number of days a prescription is intended to cover.
 - k. **Description:** Describe procedure or service.
9. **OTHER REMARKS/JUSTIFICATION/SPECIAL CIRCUMSTANCES:** Enter sufficient justification for adjustment. Indicate the service line and date of service. Attach required reports.

DEPARTMENT OF LABOR AND INDUSTRIES
OLYMPIA, WASH 98504

007589

REMITTANCE ADVICE

PROVIDER'S NAME
PROVIDER'S STREET ADDRESS
CITY, STATE ZIP

PAYEE PROVIDER NUMBER 0000000 REMIT ADVICE # XXXXXX WARRANT REGISTER NUMBER 60048 DATE 03/30/2001 PAGE X

CLAIM NUMBER	NAME	I	PATIENT ACCT/RX NUMBER	ICN	SERVICE FROM	DATES TO	UNIT OF SVC	PROCEDURE REVENUE NDC	BILLED CHARGES	ALLOWED	TAX OR NON- COVD CHARGES	PAYABLE	EOB CODES
<i>PAID BILLS - PRACTITIONER BILL</i>													
P000000	XXXXXXX	X	XXXXXXXXXX	00101825045000200	121300	121700	1	XXXXXX	XX.XX	XX.XX	0.00	XX.XX	
					121300	121700	1	XXXXXX	XX.XX	XX.XX	0.00	XX.XX	
					121300	121700	1	XXXXXX	XX.XX	XX.XX	0.00	XX.XX	
					121300	121700	1	XXXXXX	XX.XX	XX.XX	0.00	XX.XX	
BILL TOTAL **									XX.XX	XX.XX	0.00	XX.XX	
***PAID BILLS TOTAL – PRACTITIONER BILLS									XX.XX	XX.XX	0.00	XX.XX	
***NUMBER OF BILLS													
									1				
<i>BILLS-IN-PROCESS - PRACTITIONER BILL</i>													
X000000	XXXXXXX	X	XXXXXXXXXX	00101725030003700	112200	112200	1	XXXXXX	X.XX	X.XX	0.00	X.XX	
					112200	112200	2	XXXXXX	XX.XX	XX.XX	0.00	XX.XX	
BILL TOTAL **									XX.XX	XX.XX	0.00	XX.XX	559
***BILLS PENDING TOTAL – PRACTITIONER BILLS									XX.XX	0.00	0.00	0.00	
***NUMBER OF BILLS-													
									1				
<i>DENIED BILLS – PRACTITIONER BILL</i>													
X000000	XXXXXXX	X	321	00101725004006000	112100	121900	1	###M##	XX.XX	0.00	0.00	0.00	045
					112100	121900	1	###A#	XXX.XX	0.00	0.00	0.00	045
					112100	121900	1	M####	XXX.XX	XXX.XX	0.00	XXX.XX	
BILL TOTAL **									XXX.XX	XXX.XX	0.00	XXX.XX	
***DENIED BILL TOTAL – PRACTITIONER BILLS									XXX.XX	XXX.XX	0.00	XXX.XX	
***NUMBER OF BILLS-													
									1				
<i>ADJUSTMENT – BILLS - PRACTITIONER BILL</i>													
X000000	XXXXXXX	X	321	00100725007101500	112100	121900	1	###M##	XX.XX-	0.00-	0.00	0.00-	
					112100	121900	1	###A#	XXX.XX-	0.00-	0.00	0.00-	
					112100	121900	1	M####	XXX.XX-	XXX.XX-	0.00	XXX.XX-	
BILL TOTAL **									XXX.XX-	XXX.XX-	0.00	XXX.XX-	CRE
***NUMBER OF BILLS-													
									2				
<i>**ADJUSTMENT TOTALS – PRACTITIONER BILL</i>													
									XXX.XX	XXX.XX	0.00	XXX.XX	

EOB 045 – Denied. Type Service/Procedure Code is invalid. Refer to current Fee Schedule for valid code.

TYPE OF SERVICE CODES:

C	Chiropractic Services	P	Physical Therapy
D	Drugless Therapeutics	V	Vocational Services
I	Inpatient	3	Medical Services
N	Nurse Practitioner Services	4	Dental
O	Outpatient	9	Ancillary Services (attendant, equipment, glasses)

PLACE OF SERVICE CODES:

- 11. Office
- 12. Patient's Home
- 21. Inpatient Hospital
- 22. Outpatient Hospital
- 23. Emergency Rm – Hospital
- 24. Ambulatory Surgical Ctr
- 25. Birthing Ctr
- 26. Military Trmt Facility
- 31. Skilled Nursing Facility
- 32. Nursing Facility
- 33. Custodial Care Facility
- 34. Hospice
- 41. Ambulance – Land
- 42. Ambulance – Air or Water
- 50. Federally Qualified Hlth Ctr
- 51. Inpatient Psychiatric Facility
- 52. Psychiatric Facility Partial Hospitalization
- 53. Community Mental Health Ctr
- 54. Intermediate Care Facility/Mentally Retarded
- 55. Residential Substance Abuse Trmt Facility
- 56. Psychiatric Residential Trmt Ctr
- 60. Mass Immunization Ctr
- 61. Comprehensive Inpatient Rehabilitation Facility
- 62. Comprehensive Outpatient Rehab Facility
- 65. End Stage Renal Disease Trmt Facility
- 71. State or Local Public Health Clinic
- 72. Rural Hlth Clinic
- 81. Independent Laboratory
- 99. Other Unlisted Facility

Directory:

FIELD SERVICE OFFICES

Aberdeen:	415 West Wishkah, Suite 1B Aberdeen WA 98520-0013 (360) 533-8200	Okanogan:	1234 2 nd Avenue S Okanogan WA 98840-0632 (509) 826-7345
Bellevue:	616 120 th Avenue NE, Suite C201 Bellevue WA 98005-3037 (425) 990-1400	Port Angeles:	1605 East Front Street, Suite C Port Angeles WA 98362-4628 (360) 417-2700
Bellingham:	1720 Ellis Street, Suite 200 Bellingham WA 98225-4600 (360) 647-7300	Pullman:	1250 Bishop Blvd SE, Suite G PO Box 847 Pullman WA 99163-0847 (509) 334-5296 1-800-509-0025
Bremerton:	500 Pacific Avenue, Suite 400 Bremerton WA 98337-1904 (360) 415-4000	Seattle:	300 W Harrison Street Seattle WA 98119-4081 (206) 281-5400
Colville:	298 South Main, Suite 203 Colville WA 99114-2416 (509) 684-7417 1-800-509-9174	Spokane:	901 N Monroe Street, Suite 100 Spokane WA 99201-2149 (509) 324-2600 1-800-509-8847
East Wenatchee:	519 Grant Road East Wenatchee WA 98802-5459 (509) 886-6500 1-800-292-5920	Tacoma:	950 Broadway Suite 200 Tacoma WA 98402-4453 (253) 596-3800
Everett:	729 100 th St SE Everett WA 98208-3727 (425) 290-1300	Tukwila:	12806 Gateway Drive PO Box 69050 Seattle WA 98168-1050 (206) 248-8240
Kennewick:	4310 W 24 th Ave Kennewick WA 99338-1992 (509) 735-0100 1-800-547-9411	Tumwater:	PO Box 44851 7273 Linderson Way SW Olympia WA 98504-4851 (360) 902-5799
Longview:	900 Ocean Beach Hwy Longview WA 98632-4013 (360) 575-6900	Vancouver:	312 SE Stonemill Dr, Suite 120 Vancouver WA 98684-3508 (360) 896-2300
Moses Lake:	3001 W Broadway Ave Moses Lake WA 98837-2907 (509) 764-6900	Walla Walla:	1815 Portland Avenue, Suite 2 Walla Walla WA 99362-2246 (509) 527-4437
Mount Vernon:	525 E College Way, Suite H Mount Vernon WA 98273-5500 (360) 416-3000	Yakima:	15 W Yakima Avenue, Suite 100 Yakima WA 98902-3480 (509) 454-3700 1-800-354-5423

*** indicates Regional Office
(Revised 7/30/2001)**